STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056412	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Care Center	7836 Reseda Blvd Reseda, CA 91335

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facilityˆfailed toˆimplement the baseline care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for one of three sampled residents (Resident 1). Theseˆdeficient practicesˆhad the potential to negatively affect the provision of care and services provided to Resident 1. Based on interview and record review, the facilityˆfailed toˆimplement the baseline care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for one of three sampled residents (Resident 1). Theseˆdeficient practicesˆhad the potential to negatively affect the provision of care and services provided to Resident 1. Findings: Duringˆaˆreview of Residentˆ1'sˆFace Sheet, theˆFace Sheetˆindicated the facility admitted Resident 1 to the facility on 5/08/2026, with diagnoses including ankylosing spondylitis (an inflammatory arthritis that causes severe, persistent pain and stiffness in the spine), dysphagia (difficulty swallowing), and hypertension (HTN- high blood pressure). During a review of Resident 1's History and Physical (H&P), dated 5/11/2025, the H&P indicated Resident 11 is able to make needs known but unable to make medical decision. During a concurrent interview and record review on 5/12/2026 at 9:10 a.m. with the Director of Nursing (DON), Residentˆ1's medical records including EMAR, baseline care plan, nurses note for the period of 5/1/2026 to 5/11/2026 were reviewed. The DON stated the baseline care plan interventions for alteration in comfort related to chronic lower back pain and opioid use were not implemented because there was no documentation to indicate that staff were monitoring or assessing Resident 1's pain daily from 5/8/2026 through 5/11/2026 night shift. The DON stated that the potential outcome of not monitoring or assessing the resident for pain is that staff would not know whether the resident is experiencing pain, which may prevent staff from providing the necessary care. The DON further stated that not implementing the care plan interventions may result in ineffective pain management. During a review of Residentˆ1's Clinical admission record, datedˆ5/08/2026 and timed at 5:24 p.m.,ˆthe record indicated Resident 1 arrived by ambulance and was accompanied by family member 1 (FAM 1). The record indicated that Resident 1 verbally reported pain and demonstrated protective body movements. The section designated to record the resident's pain level and pain notes were left blank. During a review of Resident 1's Baseline Care Plan Report, with an effective date of 5/09/2026, the Baseline Care Plan Report indicated Resident 1 has alteration in comfort/pain related to chronic lower back pain and opioid (strong pain medication) use. The care plan included interventions to administer pain medication as ordered/needed, notify physician if pain medications are ineffective, monitor and assess for pain daily, monitor for adverse reactions/side effects. The goal indicated for Resident 1 to have decreased pain within one (1) hour of intervention/s daily for three (3) months. During a concurrent interview and record review on 5/11/2026 at 3:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Controlled Drug Record (CDR-accountability record of medications that are considered to have a strong potential for abuse), was reviewed. LVN 1 stated the CDR indicated Resident 1 received the first dose of pain medication which was hydrocodone-acetaminophen oral tablet 5-325 milligrams (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(mg-unit of measurement) on 5/9/2026 at 12:00 p.m. During a concurrent interview and record review on 5/11/2026 at 3:11 p.m. with LVN 1, Resident 1's Controlled Drug Record for Liquid Only, was reviewed. LVN 1 stated the record indicated Resident 1 received Morphine Sulfate Oral Solution 10ˆmg/5ˆmilliliters (ml-unit of volume), 5ˆml by mouth four times daily for chronic back pain on the following dates: 1. Date 5/9/2026, administration time 1:42 p.m., amount 5 ml, remaining 95 ml 2. Date 5/9/2026, administration time 7:15 p.m., amount 5 ml, remaining 90 ml 3. Date 5/10/2026, administration time 11:46 a.m., amount 5 ml, remaining 85 ml 4. Date 5/10/2026, administration time 5:00 p.m., amount 5 ml, remaining 80 ml 5. Date 5/10/2026, administration time 9:00 p.m., amount 5 ml, remaining 75 ml 6. Date 5/11/2026, administration time 9:00 a.m., amount 5 ml, remaining 70 ml 7. Date 5/11/2026, administration time 11:45 a.m., amount 5 ml, remaining 65 ml During a concurrent interview and record review on 5/12/2026 at 9:10 a.m. with the Director of Nursing (DON), Residentˆ1's medical records including EMAR, baseline care plan, nurses note for the period of 5/1/2026 to 5/11/2026 were reviewed. The DON stated the baseline care plan interventions for alteration in comfort related to chronic lower back pain and opioid use were not implemented because there was no documentation to indicate that staff were monitoring or assessing Resident 1's pain daily from 5/8/2026 through 5/11/2026 night shift. The DON stated that the potential outcome of not monitoring or assessing the resident for pain is that staff would not know whether the resident is experiencing pain, which may prevent staff from providing the necessary care. The DON further stated that not implementing the care plan interventions may result in ineffective pain management. During a review of the facility`s Policy and Procedures (P&P) titled Baseline Care Plan, last reviewed on 11/20/2025, the P&P indicated nursing Facilities are required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. The intent of this policy is to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a copy of the baseline care plan, IDT summary, and list of medications. Baseline Care Plan will only contain Minimum healthcare information including but not limited to initial goals, physician orders, therapy services, social services and PASARR recommendations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to: 1. Complete a pain assessment upon admission when Resident 1 verbalize pain on 5/8/2026 at approximately 5:24 p.m. 2. Provide timely pain management interventions for Resident 1, including non-pharmacological and pharmacological interventions (administer pain medications, including available house stock acetaminophen and controlled medications [CM-medications which have a potential for abuse and ay also lead to physical or psychological dependence] accessible through the emergency kit [e-Kit] such as hydrocodone-acetaminophen [Norco]). 3. Document medication administration of Norco and morphine sulfate in the electronic medication administration record (eMAR). 4. Conduct and document pre-administration and post-administration pain assessments for Resident 1. These deficient practices had the potential to result in unrelieved pain, emotional distress, diminished comfort, and a decline in psychosocial wellbeing and overall quality of life. Findings: Duringˆaˆreview of Residentˆ1'sˆFace Sheet, theˆFace Sheetˆindicated the facility admitted Resident 1 admitted to the facility on [DATE], with diagnoses including ankylosing spondylitis (an inflammatory arthritis that causes severe, persistent pain and stiffness in the spine), dysphagia (difficulty swallowing), and hypertension (HTN- high blood pressure). During a review of Resident 1's History and Physical (H&P), dated 5/11/2025, the H&P indicated Resident 11 is able to make needs known but unable to make medical decision. During a review of Residentˆ1's Clinical admission record, datedˆ5/08/2026 and timed at 5:24 p.m.,ˆthe record indicated Resident 1 arrived by ambulance and was accompanied by family member 1 (FAM 1). The record indicated that Resident 1 verbally reported pain and demonstrated protective body movements. The section designated to record the resident's pain level and pain notes were left blank. During a review of a facility provided text messages obtained on the facility's physician communication phone called Red phone, between Physician 1 and the facility's Registered Nurse 1 (RN 1), the text message dated 5/08/2026 at 5:17 p.m., indicated that RN 1 texted Physician 1 that Resident 1 was admitted to the facility. The text messages dated 5/08/2026 at 5:26 p.m., indicated that Physician 1 responded and instructed RN 1 to follow the general acute care hospital 1 (GACH 1) discharge medication list exactly. During a review of Resident 1's GACH 1 of discharge medication list dated 5/8/2026, the list included the following medications to be started: -Acetaminophen 500 milligrams (mg- unit of measurement) tablet oral table take two (2) tablets by mouth every 8 hours as needed for mild pain. -Hydrocodone-Acetaminophen (Norco) 5-325 mg. take 1 tablet by mouth every six (6) hours as needed for moderate to severe pain. -Morphine 10 mg/5 milliliters (unit of volume) take 5 ml by mouth four times a day for chronic back pain During a concurrent interview and record review on 5/11/2026 at 3:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Controlled Drug Record (CDR-accountability record of medications that are considered to have a strong potential for abuse), was reviewed. LVN 1 stated the CDR indicated Resident 1 received the first dose of pain medication which was hydrocodone-acetaminophen oral tablet 5-325 milligrams (mg-unit of measurement) on 5/9/2026 at 12:00 p.m. During an interview on 5/11/2026 at 12:27 p.m. with Resident 1, Resident 1 stated that she was admitted to the facility on [DATE] at around 5 p.m. Resident 1 stated she reported to the admitting nurse (unable to recall the name) that she has severe pain in her lower back but did not receive any pain medication until the next day around 12 p.m. (approximately 18 hours later). Resident 1 stated not receiving the pain medication made her very angry and frustrated. During an interview on 5/11/2026 at 12:35 p.m., with FAMˆ1, FAM 1 stated that Residentˆ1 was admitted to the facility on [DATE] in the afternoon at around 5:00 p.m. FAMˆ1 reported that Residentˆ1 had been receiving routine pain medication at GACHˆ1, however, upon admission to the facility, the resident did not receive the routine pain medication until 5/9/2026 around noon. FAMˆ1 stated that the admitting nurse told FAM 1 that the medication was not available and that Physicianˆ1 had not approved the medication orders. FAM 1 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 1 was in pain for more than 18 hours. FAM 1 further stated that every four to six hours he requested staff to administer Resident 1's pain medication, however, staff report that Physician 1 did not approve the orders. During a concurrent interview and record review on 5/11/2026 at 3:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's form titled Controlled Drug Record, was reviewed. The LVN 1 stated the form indicated Resident 1 received her first dose of pain medication which was hydrocodone-acetaminophen oral tablet 5-325 mg on 5/9/2026 at 12:00 p.m. During a concurrent interview and record review on 5/11/2026 at 3:11 p.m. with LVN 1, Resident 1's form titled Controlled Drug Record for Liquid Only, was reviewed. The LVN 1 stated the form indicated Resident 1 received morphine sulfate oral solution 10ˆmg/5ˆmL, 5ˆmL by mouth four times daily for chronic back pain on: Date 5/9/2026, administration time 1:42 pm, amount 5 ml, remaining 95 ml Date 5/9/2026, administration time 7:15 pm, amount 5 ml, remaining 90 ml Date 5/10/2026, administration time 11:46 am, amount 5 ml, remaining 85 ml Date 5/10/2026, administration time 5:00 pm, amount 5 ml, remaining 80 ml Date 5/10/2026, administration time 9:00 pm, amount 5 ml, remaining 75 ml Date 5/11/2026, administration time 9:00 am, amount 5 ml, remaining 70 ml Date 5/11/2026, administration time 11:45 am, amount 5 ml, remaining 65 ml During a concurrent interview and record review on 5/11/2026 at 3:17 p.m. with LVNˆ1, Residentˆ1's eMAR for the period of 5/1/2026 to 5/11/2026 was reviewed. LVN 1 stated the eMAR indicated: -no documentation/administration of the order hydrocodone-acetaminophen (Norco) 5-325 mg tablet mouth every 6 hours as needed for severe pain (on the numeric pain scale, 0-no pain, 10-worst pain imaginable) from 5/8/2026 to 5/11/2026. LVN 1 stated that the boxes corresponding the dates for administration were marked with X which means the medication was not administered. -no documentation/administration of morphine sulfate oral solution 10 mg/5ml take 5 ml by mouth four times a day for chronic back pain from in EMAR from 5/8/2026 through 5/11/2026 at 1 p.m. LVN 1 stated the boxes corresponding the dates and times for administration were marked with X which means the medication. LVN 1 stated she administer Morphine 5 ml around 1 p.m. on 5/11/2026.During a concurrent interview and record review on 5/11/2026 at 3:21 p.m. with LVNˆ1, Residentˆ1's eMAR and Nurses Notes from 5/8/2026 through 5/11/2026 were reviewed. LVN 1 stated there is no documentation of daily pain assessment indicating pain level, location, intensity, and whether the pain medication was effective or not. LVNˆ1 stated that the potential outcome of the lack of documentation and assessment is that Residentˆ1 may continue to experience pain, anger, and frustration due to unmanaged pain. During a concurrent interview and record review on 5/11/2026 at 4:00 p.m. with the DON, a text message exchange from the facility's physician communication device (Red phone) between Physician 1 and RN 1, dated 5/08/2026 at 5:17 p.m., was reviewed. The DON stated that the text indicated RN 1 notified Physician 1 on 5/08/2026 at 5:17 p.m. that Resident 1 had been admitted to the facility. The text messages further showed that on 5/08/2026 at 5: 24 p.m., Physician 1 responded with an order to continue all medications as prescribed by GACH 1. The DON stated that based on this text message, nursing staff should have carried out all the orders from GACH 1, including medication administration. During a concurrent interview and record review on 5/11/2026 at 4:06 p.m. with the Director of Nursing (DON), Residentˆ1's Clinical admission Record dated 5/8/2026 and timed 5:24 p.m. was reviewed. The DON stated the record indicated that Resident 1 verbalized pain and also showed protective body movement which was an indication of pain. The DON stated she could not provide any documentation by licensed nurses that they (licensed nurses) completed a pain assessment. The DON stated based on facility policy RN 1 should have conducted a pain assessment such as location, intensity, duration, .The DON stated pain assessment in necessary to provide pain management. During a concurrent interview and record review on 5/11/2026 at 4:10 p.m. with the DON, Residentˆ1's eMAR and progress notes from 5/8/206 through 5/11/2026 were reviewed. The DON stated she could not provide any documentation that licensed nurses provided nonpharmacological interventions and/or pharmacological intervention such as administering pain medications available as house supply such as acetaminophen and medications available from the Emergency Medication Kit (EKit), such as (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydrocodone-Acetaminophen (Norco) 5-325 MG. The DON stated that from approximately 5:30 p.m. on 5/8/2026, when Resident 1 reported pain, until 12:00 p.m. on 5/9/2026, when Resident 1 received her first dose of pain medication, there was no documentation showing that pain management interventions were provided. The DON further stated that the potential outcome of not providing the necessary care is that Resident 1 may continue to experience pain, which could negatively affect her mood. During a concurrent interview and record review on 5/11/2026 at 4:40 p.m. with the DON, Residentˆ1's medical records including eMAR, progress notes, Controlled Drug Record, and Controlled Drug Record for Liquid Only from 5/8/2026 through 5/11/2026 were reviewed. The DON stated Resident 1 received the first dose of pain medication which was hydrocodone-acetaminophen oral tablet 5-325 mg on 5/9/2026 at 12:00 p.m., almost 18 hours after Resident 1 verbalized pain. The DON stated there was no preˆadministration and postˆadministration pain assessments completed on 5/9/2026 at 12:00 p.m. The DON stated that the licensed nurse should have completed a pre-administration pain assessment, including determining the resident's pain level, location, and intensity, in order to identify the severity of the pain and administer the appropriate medication. The DON stated the potential outcome of not conducting pain assessment is overmedication or undermedication and not determining the effectiveness of the pain medication. During a concurrent interview and record review on 5/11/2026 at 4:50 p.m. with the DON, Residentˆ1's eMAR from 5/1/2026 through 5/11/2026 was reviewed. The DON stated that the eMAR indicated licensed nurses did not document Residentˆ1 received hydrocodone acetaminophen or morphine in the eMAR or emergency MAR from 5/1/2026 to 5/11/2026. The DON stated that, according to facility policy, nursing staff are required to document the administration of all medications in the MAR to prevent medication errors. During a concurrent interview and record review on 5/12/2026 at 9:10 a.m. with the DON, Residentˆ1's medical records including eMAR, progress notes from 5/1/2026 through 5/11/2026 were reviewed. The DON stated she is unable to provide any documentation that licensed nurses monitored and assessed Resident 1's pain daily from 5/8/2026 through 5/11/2026 during the night shift. The DON stated that the potential outcome of not monitoring and assessing the resident for pain is that staff would not know whether the resident is experiencing pain, which may prevent them from providing the necessary care. During a review of the facility`s Policy and Procedures (P&P) titled Pain Assessment and Management, last reviewed on 11/20/2025, the P&P indicatedthe purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Assessing Pain: During the comprehensive pain assessment gather the following information as indicated from the resident (or legal representative): a. History of pain and its treatment, including pharmacological and non-pharmacological interventions; b. Characteristics of pain: (1) Location of pain; (2) Intensity of pain (as measured on a standardized pain scale); (3) Characteristics of pain (e.g., aching, burning, crushing, numbness, burning, etc.); (4) Pattern of pain (e.g., constant or intermittent); and (5) Frequency, timing and duration of pain. c. Impact of pain on quality of life; d. Factors that precipitate or exacerbate pain; e. Factors and strategies that reduce pain; and f. Symptoms that accompany pain (e.g., nausea, anxiety). Discuss with the resident (or legal representative) his or her goals for pain management and satisfaction with the current level of pain control. Implementing Pain Management Strategics: I. Non- pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: a. Environmental -adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.; b. Physical -ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; c. Exercise -range of motion exercises to prevent muscle stiffness and contractures; and d. Cognitive or Behavioral -relaxation, music, diversions, activities, etc. 2. Pharmacological interventions (i.e., analgesics) may be prescribed to manage pain, however they do not usually address the cause of pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and can have adverse effects on the resident (e.g., drowsiness, increased risk of falling; loss of appetite). 3. The physician and staff will establish a treatment regimen based on consideration of the following: a. The resident's medical condition; b. Current medication regimen; c. Nature, severity and cause of the pain; d. Course of the illness; and e. Treatment goals. Implement the medication regimen as ordered, carefully documenting the results of the interventions. Monitoring and Modifying Approaches: Monitor the following factors to determine if the resident's pain is being adequately controlled: a. The resident's response to interventions and level of comfort over time; b. The status of the underlying causc(s) of pain, if identified previously; and c. The presence of adverse consequences to treatment. Documentation: Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record. During a review of the facility`s Policy and Procedures (P&P) titled admission Criteria, last reviewed on 11/20/2025, the P&P indicated our facility admits only residents whose medical and nursing care needs can be met. Admit residents who can be cared for adequately by the facility; Residents are admitted to this facility as long as their medical needs are evaluated and can be met adequately by the facility. During a review of the facility`s Policy and Procedures (P&P) titled Controlled Medication, last reviewed on 11/20/2025, the P&P indicated the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Upon administration MAR and control substance log must be signed, thereafter providing medication date and time. During a review of the facility`s Policy and Procedures (P&P) titled Administrating Medication, last reviewed on 11/20/2025, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on interview and record review the facility failed to implement its policy and procedure titled, Physician's Untimely Visit, for one of three sampled residents (Resident 1) when Resident 1's physician did not conduct the initial comprehensive visit within 72 hours of admission. This failure had the potential for the physician to miss identifying and addressing Resident 1's early care needs, including pain management. Findings:Duringˆaˆreview of Residentˆ1'sˆFace Sheet, theˆFace Sheetˆindicatedˆ Resident 1ˆwas admitted to theˆfacilityˆonˆ5/08/2026, with diagnoses includingˆankylosing spondylitisˆ(anˆinflammatory arthritis that causes severe, persistent pain and stiffness in the spine),ˆdysphagiaˆ(difficultyˆswallowing),ˆandˆhypertension (HTN- high blood pressure).ˆˆ ˆDuring a review of Resident 1'sˆHistory and Physical (H&P), datedˆ5/11/2025, the H&Pˆindicatedˆ Resident 11 ˆisˆable toˆmake needs known but unable to make medical decision.ˆˆ ˆ During a review of the facility census dated 5/08/2026, the census reflected Resident 1's name as an active resident. During a review of Residentˆ1's Clinical admission Record (CAR), datedˆ5/08/2026 and timed 5:24 p.m.,ˆthe CAR indicated Resident 1 arrived by ambulance and accompanied by family member 1 (FAM 1).During a review of a facility provided text messages obtained on the facility's physician communication phone called Red phone, between Physician 1 and the facility's Registered Nurse 1 (RN 1), the text message dated 5/08/2026 at 5:17 p.m., indicated that RN 1 texted Physician 1 that Resident 1 was admitted to the facility. The text messages dated 5/08/2026 at 5:26 p.m., indicated that Physician 1 responded and instructed RN 1 to follow the general acute care hospital 1 (GACH 1) discharge medication list exactly. During a concurrent interview and record review on 5/12/2026 at 9:24 a.m., the Director of Nursing (DON) stated that Resident 1's physician had not conducted a visit from the admission date of 5/8/2026 through 5/12/2026 (more than 72 hours). The DON further stated she was unable to provide any documentation showing that either the attending physician or the medical director had visited Resident 1 during this period. During a concurrent interview and record review on 5/12/2026 at 9:24 a.m. with the DON, the facility's policy titled Physician's Untimely Visit was reviewed. The DON stated that, according to the policy, physicians are required to conduct a visit within 72 hours of a resident's admission, emphasizing that this timeframe is important to ensure necessary care and assessment are provided promptly. During a review of the facility`s Policy and Procedures (P&P) titled Physician's Untimely Visit, last reviewed onˆ11/20/2025, the P&Pˆindicatedˆto provide appropriate physician services within a timely manner. Physician visits are to be completed within 72 hours of admission. Administrator shall notify physicians to comply with facility policy as well as state and federal regulations. If the delinquent physician does not respond to the above measure, the Medical Director is to visit residents and document visits in clinical record to ensure compliance with regulations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to accurately and safely provide pharmaceutical services to one of three sampled residents (Resident 1) by failing to: 1. Ensure licensed nurses sign/initial the form titled Controlled (medications which have a potential for abuse and may also lead to physical or psychological dependence) Drugs Count Record at the end of each shift to verify the count and accountability of controlled medications. 2. Ensure Licensed nurses documented the correct remaining amount of morphine sulfate in the form titled Controlled Drug Record for Liquid Only. 3. Ensure the date and time of administration of morphine sulfate was accurately documented in Resident 1's Antibiotic orˆControlled Drug Record for Liquid Only and electronic medication administration record (eMAR). These deficient practices had the potential to result in inaccurate narcotic counts, inability to reconcile controlled substances, and increased risk for medication diversion (unauthorized taking, use, or distribution of a resident's prescribed medications, particularly controlled substances, for purposes other than the resident's intended medical treatment) or unrecognized medication errors. 4. Ensure accurate medication reconciliation (the process of verifying and matching a resident's preˆadmission medications, including the last doses administered, with the orders to be given upon admission to prevent omissions, duplications, dosing errors, and to maintain continuity of care) for Resident 1. The facility did not verify the last dose of medications administered at General Acute Care Hospital 1 (GACH 1) and did not ensure the proper timing of the next scheduled dose for Resident 1. This failure had the potential to result in medication errors, including duplicate dosing, missed doses, and improper timing of administration. Such errors place residents at risk for adverse drug effects, inadequate symptom management, and avoidable harm. Findings:^^ ˆDuringˆaˆreview of Residentˆ1'sˆFace Sheet, theˆFace SheetˆindicatedˆResident 1ˆwas admitted to theˆfacilityˆonˆ5/08/2026, with diagnoses includingˆankylosing spondylitisˆ(anˆinflammatory arthritis that causes severe, persistent pain and stiffness in the spine),ˆdysphagiaˆ(difficultyˆswallowing),ˆandˆhearth failure (heart can't pump enough blood to meet the body's needs, causing fluid buildup in the lungs, legs, and other tissue).^^ ˆDuring a review of Resident 1'sˆHistory and Physical (H&P), datedˆ5/11/2025, the H&PˆindicatedˆResident 11ˆisˆable toˆmake needs known but unable to make medical decisions.^^ During a review of a facility provided text messages obtained on the facility's physician communication phone called Red phone, between Physician 1 and the facility's Registered Nurse 1 (RN 1), the text message dated 5/08/2026 at 5:17 p.m., indicated that RN 1 texted Physician 1 that Resident 1 was admitted to the facility. The text messages dated 5/08/2026 at 5:26 p.m., indicated that Physician 1 responded and instructed RN 1 to follow GACH 1 discharge medication list exactly. During a review of Resident 1's GACH record, the record indicated Resident 1's medication list as follows: -Acetaminophen (pain medication)ˆ500 milligrams (mg-unit of measurement) tabletˆoral (by mouth) tableˆtake two (2)ˆtabletsˆbyˆmouth every 8 hours as needed for mild pain. -Cyanocobalamin (vitamin) 2500 micrograms (mcg--unit of measurement) dissolve one tablet under the tongue daily. ^^^ -Hydrocodone-Acetaminophenˆ(Norco-strong pain medication) 5-325 mgˆtakeˆ1 tablet by mouth every six (6) hours as needed forˆmoderate toˆsevere pain.^^ -Bisac-Evac (stool softener)10 mg unwrap and insert suppository (rectally) daily as needed for constipation -Ferrous Gluconate (iron supplement)324 mg tablet take one (1) tablet by mouth every Monday, Wednesday, and Friday. -Levothyroxine (medication for underactive thyroid)100 mcg tablet take 1 tablet daily and skip every third day. -Sennosides (stool softener) 8.6 mg tab take 1 tablet by mouth two (2) times a day. Hold for loose stool. -Furosemide (Lasix-medication that helps the body remove excess water by increasing urine production) oral tablet 20 mg take two (2) tablets two times a day by mouth for seven (7) days, then take 1 tablet by mouth once daily. If weight gain greater than three (3) pounds or more shortness of breath or more leg swelling, then return to 2 tablets by mouth two times a day until symptoms (continued on next page)

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	056412	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resolve -Metoclopramide (medication to prevent nausea and vomiting) five (5) mg tablet take 1 tablet by mouth 3 times a day as needed for nausea or vomiting. -Morphine (storing pain medication) 10 mg/5 ml Solution take five (5) ml by mouth 4 times a day for chronic back pain. -Ondansetron (medication to prevent nausea and vomiting) take four (4) mg dissolve 1 tablet on the tongue 3 times a day 30 minutes before meals to prevent nausea. -Pantoprazole (reduces stomach acid production) 40 mg take 1 tablet by mouth two (2) times a day 30 minutes before breakfast and dinner for esophagitis (inflammation or irritation of the tube connecting the throat to the stomach). -Polyethylene Glycol (medication to prevent constipation) 3350 17 gram (unit of measurement)/dose powder take 17 g by mouth 2 times a day to prevent constipation. Mix powder in 8 ounces of water or juice (17 g = 1 tablespoonful) -Potassium Chloride (medication to prevent or treat low potassium levels) 20 milliequivalent (mEq-unit of measurement)/15 milliliters (ml-measurement of volume) of take 5.6 ml by mouth daily for 7 days while taking high dose furosemide, then stop. -Prucalopride (stool softener) 1 mg tablet take 1 tablet by mouth daily for gastroparesis (a condition where stomach muscles move food slowly, despite no physical blockage). -Sucralfate (medication to prevent coating of the stomach) 1 gram tablet take 1 tablet by mouth before meals and at bedtime. Dissolve 1 tablet in 20 ml (4 teaspoonfuls) of water to make a slurry mixture and take the entire dose by mouth 4 times a day.During a concurrent interview and record review onˆ5/11/2026ˆatˆ3:11ˆp.m. with LVNˆ1,ˆResident 1's form titled Controlled Drug Record for Liquid Only,ˆwasˆreviewed.ˆ LVN 1ˆstatedˆthe formˆindicatedˆResidentˆ1ˆreceivedˆMorphine Sulfate Oral Solution 10ˆmg/5ˆmL, 5ˆmL by mouth four times daily for chronic back painˆon the following dates and times and the remaining amount of morphine sulfate after administration: Date 5/9/2026, administration time 1:42 pm, amount 5 ml,ˆremainingˆ95 mlˆˆ Date 5/9/2026, administration time 7:15 pm, amount 5 ml,ˆremainingˆ90 mlˆˆ Date 5/10/2026, administration time 11:46 am, amount 5 ml,ˆremainingˆ85 mlˆˆ Date 5/10/2026, administration time 5:00 pm, amount 5 ml,ˆremainingˆ80 mlˆˆ Date 5/10/2026, administration time 9:00 pm, amount 5 ml,ˆremainingˆ75 mlˆˆ Date 5/11/2026, administration time 9:00ˆam, amount 5 ml,ˆremainingˆ70 mlˆˆ Date 5/11/2026, administration time 11:45 am, amount 5 ml,ˆremainingˆ65 mlˆˆ During a concurrent observation and interview on 5/11/2026 at 3:09 p.m. with LVN 1 at Nursing Station 2 Medication Cart 1, Resident 1's morphine sulfate 10 mg/5 ml bottle was observed. LVN 1 stated that the medication bottle showed 77 mL remaining. During a concurrent interview and record review on 5/11/2026 at 3:11 p.m. with LVN 1, Resident 1's form titled Controlled Drug Record for Liquid Only was reviewed. LVN 1 stated the form indicated 65 mL of Morphine Sulfate Oral Solution 10 mg/5 ml remaining, however, observation of the bottle showed 77 mL remaining. LVN 1 stated there was a 12 mL discrepancy, which could mean that Resident 1 may not have received the required dose for pain management or that the documentation was inaccurate. During a concurrent interview and record review on 5/11/2026 at 3:16 p.m. with LVN 1, Resident 1's eMAR for from 5/1/2026 through 5/11/2026 was reviewed. LVN 1 stated the eMAR indicated that the order Morphine Sulfate Oral Solution 10 mg/5 mL, 5 mL by mouth four times daily for chronic back pain, was administered at 1:00 p.m. on 5/11/2026. However, the Controlled Drug Record for Liquid Only form documented that the same dose was administered at 11:45 a.m. LVN 1 stated she actually administered the medication at 1:45 p.m., but incorrectly documented the time as 11:45 a.m. LVN 1 stated the potential outcome of not accurately documenting the time of administering a medication is that the resident may receive doses too early or too late, which could lead to inadequate pain control, overmedication, or other adverse effects. During a concurrent interview and record review on 5/11/2026 at 3:28 p.m. with LVN 1, the facility document titled Controlled Drugs Count Record, for the month of May 2026, Station Cart 2, was reviewed. LVN 1 stated the sections designated for the nurse on duty and nurse off duty remained blank, with no signatures or initials on the following dates and shifts: 5/9/2026, 7 a.m. to 3 p.m. - Nurse off, no signature 5/10/2026, 7 a.m. to 3 p.m. - Nurse off, no signature 5/10/2026, 3 p.m. to 11 p.m. - Nurse on, no signature 5/10/2026, 3 p.m. to 11 p.m. - Nurse off, no signature 5/10/2026, 11 p.m. to 7 a.m. - Nurse on, no signature 5/11/2026, 11 p.m. to 7 a.m. - (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse off, no signature LVN 1 stated that according to facility policy, during each shift change the licensed nurse must verify and count all narcotics together with the incoming nurse. After completing the count, both nurses (nurse off and nurse on) are required to initial or sign the Controlled Drug Count Record to ensure accuracy and prevent any missing controlled medications. LVN 1 stated the potential outcome of not completing the narcotic count is that discrepancies may occur and controlled medications may be missing or in excess. During an interview on 5/11/2026 at 3:33 p.m., with the DON, the stated that according to facility policy, during each shift change the licensed nurse must verify and count all narcotics together with the incoming nurse. After completing the count, both nurses are required to initial the Controlled Drug Count Record to ensure accuracy. The DON stated the potential outcome of not completing the narcotic count is that discrepancies may occur, and controlled medications may be missing or unaccounted for. During a concurrentˆinterviewˆand recordˆreviewˆon 5/11/2026 at 4:00ˆp.m. with theˆDON, a text message exchange from the facility's physician communication device (Red phone) between Physician 1 and RN 1, dated 5/08/2026 at 5:17 p.m., was reviewed. The DONˆstatedˆthat the text showed RN 1 notified Physician 1 on 5/08/2026ˆat 5:17 p.m.ˆthat Resident 1 had been admitted to the facility at 5 p.m. The text messages further indicated that onˆ5/08/2026 at 5: 24 p.m.,ˆPhysician 1 responded with an order to continue all medicationsˆas prescribed byˆGACH 1. The DONˆstatedˆthat based on this text message, nursing staff should have carried out all medication orders fromˆGACH 1.ˆ During an interview on 5/12/2026 at 10:40 a.m. with the DON, the DON stated that licensed nurses should have clarified the time of the last dose of medication administered at GACH 1 to determine whether Resident 1 required another dose upon admission or whether it was safe for the facility to administer the next dose of medication. The DON stated that licensed nurses could have administered medications such as Lasix 20 mg twice daily, hydrocodone-acetaminophen 325 mg for pain as needed from the Emergency Medication Kit (eKIT), and acetaminophen from the house supply. The DON stated that the potential outcome of not administering Lasix is fluid overload and shortness of breath, and the potential outcome of not administering pain medication is that the resident will experience unmanaged pain. During a concurrent interview and record review of Resident 1's medical records including progress notes on 5/12/2026 at 10:46 a.m. with the DON, the DON stated she was unable to provide any documentation showing that staff verified the last dose of medications administered at the hospital or when the next dose was due for Resident 1. The DON stated that failing to verify the last dose could result in a missed dose or an overdose, both of which pose a risk to resident safety. The DON confirmed that Resident 1 did not receive any medications on 5/8/2026, based on a review of the EMAR. During a review of the facility`s Policy and Procedures (P&P) titled ˆControlled Medication,ˆlast reviewed onˆ11/20/2025, the P&Pˆindicatedˆupon administrationˆMAR and control substance log must be signed, there after providing education date and time.ˆˆControlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately. ˆDuring a review of the facility`s Policy and Procedures (P&P) titled ˆAdministratingˆMedication,ˆlast reviewed onˆ11/20/2025, the P&Pˆindicatedˆmedications are administered in a safe andˆtimelyˆmanner, and as prescribed.ˆMedications are administeredˆin accordance withˆprescriber orders, including any requiredˆtime frame.ˆˆThe individual administering the medication initials the resident's MAR on theˆappropriate lineˆafter giving each medication and before administering the next ones.ˆMedications are administered within one (I) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). During a review of the facility`s Policy and Procedures (P&P) titled Admissionˆ Criteria, last reviewed onˆ11/20/2025, the P&Pˆindicatedˆour facility admits only residentsˆwhoseˆmedical and nursing care needs can be met.ˆAdmit residents who can be cared for adequately by the facility;ˆResidents are admitted to this facilityˆas long asˆtheir medical needs are evaluated and can be met adequately by the facility.ˆˆ ˆ

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for one of three sampled residents (Resident 1) by failing to complete Resident 1's Clinical admission Record and admission Notes. This failure had the potential to delay identification of Resident 1's needs and impact timely care planning. Findings: Duringˆaˆreview of Residentˆ1'sˆFace Sheet, theˆFace Sheetˆindicated Resident 1 was admitted to the facility on [DATE], with diagnoses including ankylosing spondylitis (an inflammatory arthritis that causes severe, persistent pain and stiffness in the spine), dysphagia (difficulty swallowing), and hypertension (HTN- high blood pressure). During a review of Resident 1's History and Physical (H&P), dated 5/11/2025, the H&P indicated Resident 11 is able to make needs known but unable to make medical decision. During a review of Residentˆ1's Document titled Clinical admission Record (CAR), datedˆ5/08/2026 and timed 5:24 p.m.,ˆthe CAR indicated Resident 1 arrived by ambulance and was accompanied by family member 1 (FAM) 1. The CAR indicated that Resident 1 verbally reported pain and demonstrated protective body movements. The section designated to record the resident's pain level and pain notes were left blank. During a review of Residentˆ1's document titled Clinical admission Record (CAR), datedˆ5/08/2026 and timed 5:24 p.m., 40 sections out of 43 sections were left blank including mental status, skin assessment, mood and behavior, mobility. During a concurrent interview and record review on 5/12/2026 at 9:48 a.m. with the Director of Nursing (DON), Residentˆ1's CAR dated 5/8/2026 and timed 5:24 p.m. was reviewed. The DON stated the CAR contains 43 sections, 40 of which were left blank. The DON stated that only three sections were completed by Registered Nurse 1 (RN 1). The DON stated that RN 1 should have completed all sections of the clinical admission record as soon as possible following Resident 1's admission. The DON also stated that four days have passed since the resident was admitted , and by this time all sections should have been completed. During a concurrent interview and record review on 5/12/2026 at 10:02 a.m. with the DON, Residentˆ1's medical record dated 5/8/2026 through 5/12/2026 including progress notes, and CAR were reviewed. The DON stated she is unable to provide any documentation that licensed nurses documented admission notes accurately and completely including date and time of the resident's admission, admitting diagnosis, the general condition of the resident upon admission, the time medications were ordered from pharmacy, the time physician orders were received and reviewed, During a concurrent interview and record review on 5/12/2026 at 10:08 a.m. with the DON, the facility policy and procedure titled admission Note dated March 20223 was reviewed. The DON stated the policy indicated that when a resident is admitted to nursing unit the admitting nurse must document admitting diagnosis, the general condition of the resident upon admission, the time medications were ordered from pharmacy, the time physician orders were received and reviewed . The DON stated that RN 1 did not follow the policy and did not document the required information. The DON stated that the potential outcome of not accurately documenting the admission note is that the facility may fail to provide the necessary care for the residents. During an interview on 5/12/2026 at 11:30 a.m. with DON, the DON confirmed she cannot provide any documentation that admission note has been completed accurately on 5/8/2026. During a review of the facility`s Policy and Procedures (P&P) titled admission Note, last reviewed on 11/20/2025, the P&P indicated preliminary resident information shall be documented upon a resident's admission to the facility. When a resident is admitted to the nursing unit, the admitting nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol: a. The date and time of the resident's admission; b. The resident's age, sex, race, and marital status; c. From where the resident was admitted (i.e., hospital, home, other facility); d. Reason for the admission; e. The admitting diagnosis; f. The general condition of the resident upon (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission; g. The time the attending physician was notified of the resident's admission; h. The time the physician's orders were received and verified; i. Description of any lab work completed, or the time specimens were sent to the lab; k.The time the dietary department was notified of the diet order; l. The time medications were ordered from the pharmacy; m. A brief description of any disabilities (i.e., blind, deaf, hemiplegia, speech impairment, paralysis, mobility, etc.); n. Any known allergies; o. Prosthesis required (i.e., glasses, dentures, hearing aid, artificial limbs, eye, etc.); p. The height and weight of the resident; q. A statement indicating that the nursing history and preliminary assessment is completed or has been started; r. Notation of any signs or symptoms of an infectious or communicable disease; s. Notation as to whether or not advance directives apply; and t. The signature and title of the person recording the data. The nurses' original admission note must remain on the resident's electronic or physical chart maintained at the nurses' station. During a review of the facility`s Policy and Procedures (P&P) titled Charting and Documentation, last reviewed on 11/20/2025, the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.